



# MEDICATION POLICIES & FORMS

# 2023

**PLEASE READ CAREFULLY & Complete all necessary forms**

Please note that all forms must be properly completed and signed by physician prior to first day of camp!

**If at all possible, alternative plans should be made to avoid the administration of medication at camp.** If you have discussed alternatives with your physician and find that medication during camp is necessary, the following procedures will be observed at Annmarie:

## EMERGENCY MEDICATION AUTHORIZATION & CARE PLAN

In the event that your child should require the use of **emergency medication** (epi-pen, inhaler, etc.) while attending an Annmarie camp, **the following documents MUST be properly completed and provided PRIOR to the first day of camp:**

- **MEDICATION ADMINISTRATION AUTHORIZATION FORM** with physician signature for each medication.
- **A COMPLETED CARE PLAN** must accompany each medication addressing your child's particular need – food allergy, asthma, diabetes, etc. For your convenience, examples of common CARE PLANS are included with this packet.

**\*\* BOTH FORMS listed above MUST be completed and signed by physician PRIOR to your child's first day of camp \*\***

**SPECIAL NOTE:** By completing the above forms and signing the attached liability release, parent/guardian gives full and unqualified permission for Annmarie staff or agents to administer the emergency medication. Further, parent/guardian understands that there is no nurse or doctor on duty at Annmarie and the Annmarie staff will call 911 and seek medical assistance in the event of an emergency.

## OTHER PHYSICIAN PRESCRIBED MEDICATIONS (excluding emergency medication – see above section)

**\*\*Campers under the age of 12--** are not permitted to self-administer medication. Camp staff will not accept or administer medication for any camper under the age of 12, aside from emergency medication (see above). Parent/Guardian will need to make arrangements to personally administer medication to their child during camp.

**\*\*Campers ages 12 & up--** must be able to understand dosage and self-administer medication. Camp Staff may assist in storing, retrieving, and returning medication to storage area. Medication must be ordered by a physician and be in original container, with original label and prescription information; placed in a zip lock baggie with campers name written in permanent black marker on baggie. **Parent/guardian must also complete and return the MEDICATION ADMINISTRATION AUTHORIZATION FORM (with physician signature) on or before the first day of camp.** A copy of this form is included in packet. When not being used, all medication will be stored in a secure unrefrigerated cabinet in the Studio School building; when campers leave the building, any necessary medications will be carried by Camp Staff in a Backpack. Medications that require refrigeration cannot be accommodated.

### CHECK LIST for camper that requires emergency medication . . .

You and your physician MUST complete the following forms PRIOR to first day of camp:

- **MEDICATION ADMINISTRATION AUTHORIZATION FORM** for each medication.
- A **CARE PLAN** must accompany each medication form.

### For campers age 12 & older

Campers ages 12 & up can self-administer medication as long as physician has completed **MEDICATION ADMINISTRATION AUTHORIZATION FORM** & the **CARE PLAN**. The forms must clearly approve medication for self-administering. Campers who arrive at camp without the proper forms will not be allowed to remain.

Any unauthorized medications found on a camper will be confiscated; parents will be notified immediately. Confiscated medications will be sent to the office where parents will be required to collect it.

**QUESTIONS?** Please contact Stacey Hann-Ruff, *Executive Director*, 410-326-4640 or [director@annmariegarden.org](mailto:director@annmariegarden.org)

**EACH medication requires this form to be completed and signed by physician. Each medication must be accompanied by a care plan. Sample care plans are attached, or you may use your own.**

# MEDICATION ADMINISTRATION AUTHORIZATION FORM

Department of Health & Mental Hygiene (DHMH)  
Center for Healthy Homes and Community Services (CHHCS)  
6 St. Paul Street, Suite 1301  
Baltimore, Maryland 21202-1608  
(410) 767-8417 FAX (410) 333-8926  
Toll Free 1-877-4MD-DHMH ext. 8417

I. CAMP OPERATOR			
This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self administer medication. A new medication administration form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or time of administration of a medication.			
<ul style="list-style-type: none"> <li>• Prescription medication must be in a container labeled by the pharmacist or prescriber.</li> <li>• Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.</li> <li>• An adult must bring the medication to the camp and give the medication to an adult staff member.</li> </ul>			
II. CAMP INFORMATION			
YOUTH CAMP NAME			
PHYSICAL ADDRESS			
CITY	STATE		ZIPCODE
III. PRESCRIBER'S AUTHORIZATION			
CHILD'S NAME		DATE OF BIRTH	
CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		EMERGENCY MEDICATION [ ] YES [ ] NO	
MEDICATION NAME	DOSE	ROUTE	
TIME/FREQUENCY OF ADMINISTRATION		IF PRN, FREQUENCY	
IF PRN, FOR WHAT SYMPTOMS			
KNOWN SIDE EFFECTS SPECIFIC TO CHILD			
MEDICATION SHALL BE ADMINISTERED (NOT TO EXCEED 1 YEAR)		FROM	TO
PRESCRIBER'S NAME/TITLE		This space may be used for the Prescriber's Address Stamp	
TELEPHONE	FAX		
ADDRESS			
CITY	STATE		
PRESCRIBER'S SIGNATURE ( <i>Parent cannot sign here</i> ) (ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)			DATE
IV. PARENT/GUARDIAN AUTHORIZATION			
I request authorized youth camp operator/staff to administer the medication as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA. I confirm that, if the medication above is a prescription medication, the child has at some point taken the medication prior to attending camp.			
PARENT/GUARDIAN SIGNATURE			DATE
HOME PHONE #	CELL PHONE #	WORK PHONE #	
V. AUTHORIZATION FOR SELF ADMINISTRATION AND SELF CARRY			
I consent that the child named above is able to self administer the medication listed. I authorize self administration of the above listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. The child named above may self carry emergency medication if indicated below.			
PRESCRIBER'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE	
PARENT/GUARDIAN'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE	

**This is a two-page SAMPLE care plan for food allergy.**  
**You may use your own care form, but it must be completed and signed by physician.**



**FARE**  
Food Allergy Research & Education

## FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

PLACE  
PICTURE  
HERE

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following foods:** \_\_\_\_\_

**THEREFORE:**

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

### FOR ANY OF THE FOLLOWING: **SEVERE SYMPTOMS**



#### **LUNG**

Short of breath,  
wheezing,  
repetitive cough



#### **HEART**

Pale, blue,  
faint, weak  
pulse, dizzy



#### **THROAT**

Tight, hoarse,  
trouble  
breathing/  
swallowing



#### **MOUTH**

Significant  
swelling of the  
tongue and/or lips



#### **SKIN**

Many hives over  
body, widespread  
redness



#### **GUT**

Repetitive  
vomiting, severe  
diarrhea



#### **OTHER**

Feeling  
something bad is  
about to happen,  
anxiety, confusion

**OR A  
COMBINATION  
of symptoms  
from different  
body areas.**

- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

### **MILD SYMPTOMS**



#### **NOSE**

Itchy/runny  
nose,  
sneezing



#### **MOUTH**

Itchy mouth



#### **SKIN**

A few hives,  
mild itch



#### **GUT**

Mild nausea/  
discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE  
SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM  
AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

### **MEDICATIONS/DOSES**

Epinephrine Brand: \_\_\_\_\_

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



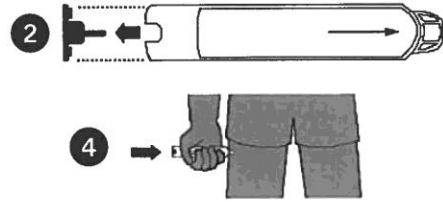


**FARE**  
Food Allergy Research & Education

## FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

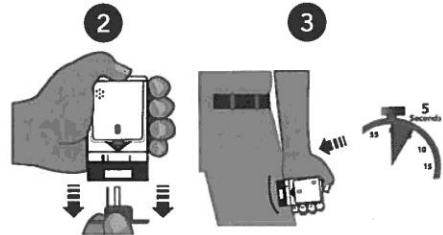
### EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



### AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



### ADRENALICK®/ADRENALICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

#### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

#### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

This is a **SAMPLE** asthma care plan.

You may use your own care form, but it must be completed and signed by physician.

**Asthma Action Plan** for: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Personal Best Peak Flow: \_\_\_\_\_ Date: \_\_\_\_\_

## GREEN ZONE

### GOOD!

#### Look For These Signs

- No cough, wheeze, or difficulty breathing
- Can sleep through the night
- Can do regular activities



#### What You Should Do

- Take your **DAILY CONTROLLER MEDICINES**
- Exercise regularly
- Medicine to take before exercise: \_\_\_\_\_

- Avoid your triggers:

Tobacco smoke

- Notes: \_\_\_\_\_

**PEAK FLOW** \_\_\_\_\_ — \_\_\_\_\_

## YELLOW ZONE

### CAUTION!

#### Look For These Signs

- Cough, wheeze, short of breath
- Waking at night due to wheeze or cough more than 2 times a month
- Can't do regular activities
- Using quick relief medicine more than 2 times a week (not counting use before exercise)



#### What You Should Do

- Keep taking your daily controller medicine
- Begin using **QUICK RELIEF MEDICINE** every 4-6 hours as prescribed (Prime it first, if needed)

- Notes: \_\_\_\_\_

- If not better in 24-48 hours, call your doctor or nurse!

- If at school, call parent

**PEAK FLOW** \_\_\_\_\_ — \_\_\_\_\_

## RED ZONE

### DANGER!

#### Look For These Signs

- Very short of breath
- Hard time walking or talking
- Skin around neck or between ribs pulls in
- Quick relief medicine not helping



#### What You Should Do

- Get help now
- Take a nebulizer treatment **OR** Take 4 puffs of quick relief medicine now

**CALL YOUR DOCTOR OR NURSE NOW!**

**OR**

**Go to the Emergency Room or Call 911**

**PEAK FLOW** less than \_\_\_\_\_

For School Age Children K-12

WHAT TO DO WHEN YOU HAVE SYMPTOMS

MEDICINES

#### Classification:

☐ Intermittent

☐ Mild Persistent

☐ Moderate Persistent

☐ Severe Persistent

#### DAILY CONTROLLER MEDICINE

#### HOW MUCH

#### HOW OFTEN

<input type="checkbox"/> Pulmicort Respules		_____ times/day
<input type="checkbox"/> Pulmicort Flexhaler		_____ puffs _____ times/day
<input type="checkbox"/> Flovent		_____ puffs _____ times/day
<input type="checkbox"/> Singulair		At bedtime
<input type="checkbox"/> Asmanex		_____ puffs At bedtime
<input type="checkbox"/> Symbicort		2 puffs 2 times/day
<input type="checkbox"/> Advair		_____ puffs 2 times/day

☐ Other \_\_\_\_\_

☐ Use Spacer

**REMINDER: GET A FLU SHOT**

#### QUICK RELIEF MEDICINE

☐ Inhaler ☐ Nebulizer

Med: \_\_\_\_\_

Dose: \_\_\_\_\_

Frequency: \_\_\_\_\_

☐ Inhaler ☐ Nebulizer

Med: \_\_\_\_\_

Dose: \_\_\_\_\_

Frequency: \_\_\_\_\_

School: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This child may carry his/her: Inhaled Asthma Medicine ☐ Yes ☐ No Epi-Pen ☐ Yes ☐ No ☐ N/A

Parent Authorizes the exchange of information about this child's asthma between the physician's office and the school nurse: ☐ Yes ☐ No

Maine law permits students to carry and use inhaled medicines and epi-pen **after** demonstrating appropriate use to the school nurse.

Please call the healthcare provider and the parent if the child is using quick relief inhaler more than 2 x per week (i.e. in excess of pre-exercise treatment)

Healthcare Provider Signature \_\_\_\_\_ Phone \_\_\_\_\_

School Nurse Signature \_\_\_\_\_

Parent Signature \_\_\_\_\_ Phone \_\_\_\_\_



# Safe Diabetes Camp Guide



Today's Date: \_\_\_\_\_  
Parent(s) Name(s): \_\_\_\_\_  
Child(ren)'s Name(s): \_\_\_\_\_  
Parent(s) Cell Phone Number: \_\_\_\_\_  
Camp site address: 13480 Dowell Road, Dowell  
Cross-streets to tell 911 operator: across from Solomons Nursing center  
Camp main phone number: 410-326-4640  
Location of where parent(s) will be: \_\_\_\_\_  
Phone number of location where parent(s) will be: \_\_\_\_\_

Times to check blood glucose (BG): \_\_\_\_\_  
Target Range: \_\_\_\_\_

High BG reading: \_\_\_\_\_  
Signs of a high BG: \_\_\_\_\_  
What to do when BG is high: \_\_\_\_\_

Low BG reading: \_\_\_\_\_  
Signs of a low BG: \_\_\_\_\_  
What to do when BG is low: \_\_\_\_\_  
(Note to parent(s): list fast-acting carbs i.e., juice, gel, glucose tabs and how much to give.)

Severely Low BG reading: \_\_\_\_\_  
Signs of a severely low BG: \_\_\_\_\_  
What to do when child is unresponsive: \_\_\_\_\_

Location of glucagon and when to administer: \_\_\_\_\_  
When to call 911: \_\_\_\_\_

Insulin Instructions. Indicate when to take insulin and how much.  
\_\_\_\_\_  
\_\_\_\_\_

Meal/Snack Times: \_\_\_\_\_  
Food to be served: \_\_\_\_\_  
Alternative Foods (if child refuses to eat): \_\_\_\_\_



## High Alert Situations - ALWAYS CALL PARENT(S) IF ANY OF THE FOLLOWING OCCURS

- Child had a severe low blood glucose
- Child took insulin but refuses to eat
- Child starts to vomit
- Other situations: \_\_\_\_\_

## Reminders:

- Watch for signs of low BG while playing/being active
- If you leave the house, take blood glucose checking supplies, insulin (if necessary) and snacks with you
- Always call parent(s) with any questions



[diabetes.org/families](http://diabetes.org/families)